Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WNG NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3646 BILLMAN AVE **BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETÉ PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE **TAG** TAG **DEFICIENCY**) Y 000 Y 000 Initial Comments Acceptable ruci This Statement of Deficiencies was generated as a result of the annual state licensure survey and complaint investigation conducted at your facility on 12/19/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 6 total beds. The facility had the following category of classified beds: Category 1 - 6 beds The facility had the following endorsements: Residential facility which provides care to elderly and/or disabled persons. The census at the time of the survey was 4. Four resident files and 2 closed resident files were reviewed and 3 employee files were reviewed. There was 1 complaint investigated during the survev. Complaint #NV00017024 Substantiated (Tags Y0026, Y0072, YA0566, Y0878, Y0923, Y0960) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be RECEIVED available to any party under applicable federal, state, or local laws. MAY 0 7 2009 The following regulatory deficiencies were BUREAU OF LICENSURE AND CERTIFICATION identified: LAS YEGAS, NEYADA If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. ortalis

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Y 026 Continued From page 1 Y 026 Y 026 449.190(3) Contents of License-Multiple Types Y 026 SS=F NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. This Regulation is not met as evidenced by: Based on observation, interview and record review, the facility was caring for 2 of 4 persons See enclosed shysicions document about currently living in the facility and 2 of 2 discharged residents with mental illnesses and Alzheimer's disease without an endorsement and failed to obtain the necessary training to care for such persons. Findings include: y 0 2 6 after the survey weident # 2 was re-enaluated by her physician and enclosed are the results done by Resident #2 was admitted on 11/24/06 with diagnoses including Advanced Dementia. Hypertension, Cardiac Arrhythmia, Improved Anemia and Urinary Tract Infection. On 12/19/08 at 1:25 PM, Resident #2 indicated she was just visiting the facility and lived in physician . Document # 1+2. another city. The resident was not sure of the date, but thought it may be after Christmas and New Year's was tonight. The resident informed the surveyor the new president came from Las Vegas and looked like us. The resident revealed This deficient practice will she drove her car to the bank to get her money. occur again

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Employee #2 indicated the family and physician wanted Resident #2 to reside in the facility. The

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 026 Continued From page 2 Y 026 employee noted the resident had a dementia diagnosis, but felt since the family and physician wanted the resident to stay in the facility it would be all right. The Physician Statement, dated 12/8/06 indicated the resident was a Category 2. Resident #4 was admitted on 8/7/08 with Resident # 4 mas re-analysted by her physician after the survey, and enclosed are the results diagnoses including Depression with Paranoia. Uterine Cancer with Hysterectomy, Arthritis and Psychosis NOS. The resident had been a patient at a behavioral health hospital on 7/23/08. made by the physician. We administrator will Employee #2 revealed resident #4 refused medications and was no longer on any monitor for compliance. He facility will be careful not to repeat the deficiency done feorber # 5 is no longer medications. Resident #5 was admitted on 2/1/07 and 4026 transferred on 1/15/08. Diagnoses included Urinary Tract Infection, Psychosis, Dementia, Hypertension, Depression, Memory Loss, History of Seizure Disorder, History of Gastroenteritis. Anxiety Disorder and Panic Disorder with Agoraphobia. The medical records indicate the resident's medications included Namenda, Dilantin, Alprazolam (Xanax) and Lexapro. Employee #2 indicated she installed a slide lock on the top of the front door due to Resident #5 eloping from the facility. The employee revealed the resident complained of her pressure being using the assessment form to to document, sue that high and wanting to go to the hospital. The employee indicated the resident was confused and felt it was in the resident's head she was ill. The employee explained the resident was admitted from a behavioral health hospital and had a mental problem.

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Resident #6 was admitted on 10/27/03 and discharged on 11/7/08. Diagnoses included Alzheimer's Disease, Dementia, Diabetes.

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AND	PLAN O	F C	ORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

BILLMAN HOUSE

3646 BILLMAN AVE LAS VEGAS, NV 89121

DILLMAN	I HOUSE L	AS VEGAS, NV 891	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 026	Continued From page 3	Y 026		
	Diverticulitis, Congestive Heart Failure and Chronic Atrial Fibrillation. The medical recoindicated the resident's medications include Aricept and Insulin Novolin 70/30. Employee #2 revealed she would check the resident's blood sugar twice a day then draft the Insulin into the syringe to assure the codose of medication. The employee indicate resident gave her own injections. The emplaso indicated the lock was left on the front because Resident #6 would try to leave the facility to walk outside. Employee #1, #2 and #3 did not receive antraining in 2008. Severity: 2 Scope: 3 Complaint #NV00017024 449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall. Provide oversight and direction for the members of the staff of the facility as necess to ensure that residents receive needed set and protective supervision and that the facilin compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapte of NRS.	ords ed e w up wrect ed the eloyee door y Y 050 all: essary rvices elity is C	Posibert # is no longer living mi The facility. Well make que that the deficiency will not occur again by assessing each resident peoperly, noing assessment form for residents and physicians assessment. The owner & the administration for couplince.	
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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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DUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY** Y 050 Continued From page 4 Y 050 This Regulation is not met as evidenced by: Based on interview, record review and after the purney, the whole staff referred to Tags y0072, y0103, y0104 4050 observation, the administrator failed to provide oversight and direction to the staff to ensure 4 of 4 residents received the needed services and protective supervision. Findings include: 40105, 40272, 40273, 40435 y0773, y0870, y0876, y0877 Please refer to Tags Y0072, Y0103, Y0104, Y0105, Y0272, Y0273, Y0435, Y0773, Y0870, yA 0890, y 0923, y 0938, y 0940 Y0876, Y0877, YA0890, Y0923, Y0938, Y0940, Y0936 4093. It was convected and understook to give needed services + protection reeded services + protection cuperision to all residents.

The administrator will monitor for compliance.

The deficient practice will not o cour again. The owner not o cour again. Severity: 2 Scope: 3 Y 072 Y 072 449.196(3) Qualications of Caregiver-Med SS=F re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication. including, without limitation, an over-the-counter medication or dietary supplement, the caregiver will manifor too for compliance must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of clack on a daily basis, training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training will receive needed and his attendance at the training; and (b) At least every 3 years, pass an examination

above fago individually If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

relating to the management of medication

approved by the Bureau.

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3105AGC 12/19/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 (X4) ID PREFIX **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG DEFICIENCY**) Y 072 Continued From page 5 Y 072 This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure 3 of 3 caregivers had completed the required three hour medication management refresher training every three years (Employee #1, #2 and #3). Findings include: Employee 1, 2 + 3 will take refresher course on medication naregenest and it "ill 6-10-09 be completed by see #13. He administator will. Employee #1 was hired on 3/5/05. The employee $|_{10}$ 12 file revealed the last medication course was completed in January 2005. There was no documented evidence of a medication refresher training completed in 2008. Employee #2 was hired on 3/5/05. The employee monifor for compliance.
Employee # 1, it are.
Scheduled to take medication file revealed the last medication course was completed on March 10, 2005. There was no documented evidence of a medication refresher training completed in 2008. Employee #3 was hired on 3/5/05. The employee file revealed the last medication course was course. Refresher course will be done every year. This completed on March 10, 2005. There was no documented evidence of a medication refresher training completed in 2008. deficient practice will not occur again. Employee #2 indicated she was not aware she needed to take a refresher course for medication

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management.

Severity: 2 Scope: 3

Complaint #NV00017024

Y 102 449.200(1)(c) Personnel File - Training Records

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The owner will monitor

this deficient practice.

all staff will take

refresher course yearly

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN B. WING _		(X3) DATE SUI COMPLET	TED .
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	ROVIDER OR SUPPLIER			MAN AVE	STATE, ZIP CODE		
BILLMAN	HOUSE			AS, NV 891	21		
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Y 102	a separate personn member of the staff	ige 6 vise provided in subsolel file must be kept for for a facility and must to the training receives	or each t include:	Y 102	of Every January; the offer of administrately is our will check and many will take that all any will take refresher as complied.	alee	
	Based on interview the facility failed to received not less the related to providing (Employee #1, #2 a Findings include:		eviews, /ees g annually residents	v 10.0	Employee 15 2 have an for medication manage 6-9+10; as complied sent document after sent after sent the survey,	C. Will mirav.	toke.
	documented evider 2008. Employee #2 was I	nired on 3/5/05. Then noe of any training ho nired on 3/5/05. Then noe of any training ho	ours in re was no	y 102	Implyee # 1, 2 + 3 8 hs. faining to done every as complied. Employee 2+3 are anot care given	it will be every	27-09.
	Employee #3 was I	nired on 3/5/05. Then nce of any training ho			Employee 2+3 are amol administrator will mo for compliance. The owner must see that all employees take 8 hrs. fraince	to it	
	information regardi The employee indi	aled she did not recei ng available classes cated she did not req ng available classes.	for 2008. uest any		take 8 hrs. fraini year.	of every	
	Severity: 1 Scor	pe: 3			certificate for france classes will be sent after course.	to HCQC	
Y 103 SS=F	449.200(1)(d) Pers	onnel File - NAC 441	A	Y 103	after comper		

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3105AGC 12/19/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) **CROSS-REFERENCED TO THE APPROPRIATE** TAG TAG DATE **DEFICIENCY**) Y 103 Continued From page 7 Y 103 NAC 449,200 1. Except as otherwise provided in subsection 2. a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential The owner and administrator care: Management of cases and suspected 9103 will make sure that this deficient practice will not occur again. cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical Both owner and administrator will monitor for compliance. Well make sure that TB testing will be done every year to all employeed and residents as compliand. facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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12/19/2008

Bureau of Health Care Quality & Compliance

STATEMENT	OF DEF	ICIENCIES
AND PLAN (OF CORRE	ECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	OOMII EETED
B. WING	

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 8		Y 103	1	
	a: (a) Physical examination or certification licensed physician that the person is in good health, is free from active tubercul any other communicable disease in a creatage; and (b) Tuberculosis screening test within the preceding 12 months, including persons history of bacillus Calmette-Guerin (BCC vaccination. If the employee has only completed the of a 2-step Mantoux tuberculin skin test preceding 12 months, then the second 2-step Mantoux tuberculin skin test or o single-step tuberculosis screening test administered. A single annual tuberculo screening test must be administered the unless the medical director of the facility designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of test documents that determination. The risk exposure and corresponding frequency examination must be determined by foll guidelines of the Centers for Disease C Prevention as adopted by reference in positive tuberculosis screening test is e from screening with skin tests or chest radiographs unless he develops symptomagestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered to subsection 3 shall submit to a chest and medical evaluation for active tuberculosing and preventive treatment offered to a person with a positive tuber screening test in accordance with the gof the Centers for Disease Control and	a state of losis and ontagious he s with a G) first step within the step of the ther must be sis ereafter, y or his sting and of of owing the ontrol and paragraph sory of a xempt oms red operations. It must be roulosis and the roulosis widelines		all Physical Exam and The festing will be done on a yearly basis. He administrative and the owner will monitor for compliance. This deficiency practice will not occur again See enclosed documents.	

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Bureau	of Health Care Quali	ty & Compliance					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 105AGC		(X2) MULTI A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS CITY	STATE, ZIP CODE	146/14	3/2000
	N HOUSE		3646 BILL	MAN AVE AS, NV 891			<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
Y 103	Prevention as adopt (g) of subsection 1 7. A medical facility employees for the control or a positive tuberor report promptly to the fany, or to the direct of the medical facility designated an infect any pulmonary syntof tuberculosis are be evaluated for tuberculosis. The skin testing (Reference of the findings include:	oted by reference in port NAC 441A.200. I shall maintain surved evelopment of pulmon with a history of turbulosis screening test the infection control sector or other personity if the medical facilication control specialisation control specialisations develop. If sypresent, the employed berculosis. I and record review, the sist (TB) documentations is and the sist (TB) documentations is sident #1, #2 and #3	eillance of onary berculosis shall specialist, in charge lity has not st, when emptoms see shall the facility he on and/or st).	Y 103		en men a	
	employee's file did resident completed testing and did not of an annual TB sk Employee #2 was I employee's file contested positive for chest x-ray report of 4/19/07. The file disurveillance form of x-ray report require for TB in 2008. Employee #3 was a contained document completed the requirement of the complete of the completed the requirement of the complete of the compl	nired on 3/5/05. The not contain document the required two-ste contain documented in test. hired on 3/5/05. The stained proof the empTB on 3/15/05 and a dated 3/16/05, 10/12/id not contain a TB signs a copy of a negative of for those who test thired on 3/5/05. The station the employee sired two-step TB skille did not contain process.	ntation the ep TB skin evidence bloyee negative (06 and ymptom e chest positive file	y103	consteted by for for	inimitation is in instruction is employed and that the contract of the contrac	e por fre

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

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PRINTED: 03/17/2009 **FORM APPROVED** Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 103 Continued From page 10 Y 103 employee received an annual one-step TB skin test for 2008. after the perior all employees went to have physical exam and energhody were in good bealth and free from any confagious y 103 The employee's file did not contain the results of physical examination or a physician certification that the employee was in a good state of health, was free from active TB and any other disease in a contagious stage Employee #2 indicated she was not aware she was required to complete an annual signs and disease. symptoms checklist. monifa for comphance. The owner will monitor Severity: 2 Scope: 3 This is a repeat deficiency from the survey completed on 8/21/07. too to avoid reoccurence of deficiences. Y 105 449.200(1)(f) Personnel File - Background Check Y 105 SS=D this deficiency will not boppen again as complied. NAC 449.200 1. Except as otherwise provided in subsection 2. a separate personnel file must be kept for each ble enclosed documents;
for compliance.

1103 Employee # ~ has signed and syntoms forme completed with positive PPD is abtained allowing for chet member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: NRS 449.176 Investigation of criminal history of

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies,

applicant for license to operate certain facility. 1. Each applicant for a license to operate a facility for intermediate care, facility for skilled nursing or residential facility for groups shall submit to the Central Repository for Nevada Records of Criminal History two complete sets of fingerprints for submission to the Federal Bureau

2. The Central Repository for Nevada

of Investigation for its report.

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Bureau of Health Care Quality & Compliance

STATEMEN	NT OF DI	EFICIENCIES
AND PLAN	OF COR	RECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

3846 BILLMAN AVE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
Y 105	Continued From page 11 Records of Criminal History shall determine whether the applicant has been convicted crime listed in paragraph (a) of subsection NRS 449.188 and immediately inform the administrator of the facility, if any, and the Division of whether the applicant has been convicted of such a crime. (Added to NRS by 1997, 442) Based on record review, the facility failed ensure 1 of 3 employees had met the background check requirements for crimine history (Employee #3).	of a n 1 of Health n	y 102 - Imployee # 1 will receive carginer 101 training on 5-28-09 by owner. a training form will be naintained Struing topic , time + instructor. See enclosed currenal fistory statement for each amployee.	
	Employee #3 was hired on 3/5/05. The en file contained two copies of the employee fingerprints dated 11/15/06. The file did not contain a background check report from the Nevada repository. Severity: 2 Scope: 1	's J	after the survey, and 4-08-c employee # 3 did another fingerprist and wasting for background check report from renada repository - DPS.	~
Y 106 SS=D	449.200(2)(a) Personnel File - 1st aid & C	PR Y 106	The administrator will monifor for compliance	
	NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition information required pursuant to subsection (a) A certificate stating that the caregiver currently certified to perform first aid and cardiopulmonary resuscitation.	on 1,	Employee # 3 did not result, thata why, he did another fingerpient. See copies ench this deficiency will not accur again will set the results of	sed.
	This Regulation is not met as evidenced Based on record review, the facility failed as are cited, an approved plan of correction must be re-	to	employee #3 fingerprint once	

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 106 Continued From page 12 Y 106 ensure 1 of 3 caregivers were trained in first aid and cardiopulmonary resuscitation (Employee #1). Findings include: after the survey, employee #1 fook her first aid requirements on 2-6-09 with American Ked cross. Employee #1 was hired 3/5/05. Cardiopulmonary 4106 resuscitation and First Aid training certification expired 5/5/06. There was no documented evidence of a current certification. Severity: 2 Scope: 1 He administrator will monitor Y 152 449.204(2) Insurance-BLC endorsement Y 152 for ampliance. SS=A This deficiency proofice NAC 449.204 2. A certificate of insurance must be furnished to will not occur the Division as evidence that the contract required by subsection 1 is in force and a license cleck employees of piration date energy 3 months to make some Pat energlody must not be issued until that certificate is furnished. Each contract of insurance must contain an endorsement providing for a notice of 30 days to the bureau before the effective date of will have theres a cancellation or nonrenewal of the policy. fo date. See enclosed documents as complied. This Regulation is not met as evidenced by:

3/28/09 with HCC Swely knows. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Based on interview and record review, the facility

failed to ensure Bureau of Licensure and Certification (BLC) endorsement providing for a notice of 30 days to BLC before the effective date

Findings include:

of a cancellation or nonrenewal of the policy.

Certificate of Liability Insurance policy did not

contain an endorsement to the bureau.

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After the survey, , The certificate of Lichility Insurance was renewed on

Bureau of Health Care Quality & Compliance

STA	TEME	NT OF	DEFI	CIENC	iES
AND	PI AN	OF C	ORRE	CTION	ı

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CO	ONSTRUCTION
A. BUILDING	
B. WING	

(X3) DATE SURVEY COMPLETED

12/19/2008

NVS3105AGC

11433 103MGC

STREET ADDRESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE

3646 BILLMAN AVE LAS VEGAS, NV 89121

DILLMAI	i nouse	.AS VEGAS, NV 891	121	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 152	Continued From page 13	Y 152	ne advinitater will memifor	12
Y 175 SS=F	Employee #2 indicated she was not aware endorsement was required. Severity: 1 Scope: 1 449.209(4)(b) Health and Sanitation-Haza NAC 449.209 4. To the extent practicable, the premises facility must be kept free from: (b) Hazards, including obstacles that imperies movement of residents within and out	of the	for comphence. The owner will moke sure That the insurance is up to See enclosed renewal date; clocuments. as complied. Dismarce co. travelers has been contacted in 5-9-09 to Fax	
	This Regulation is not met as evidenced to Based on observation, the facility was not hazards. Findings include: On 12/19/08 at 12:45 PM during the facility bed was up against a gas fireplace in bed #4. Resident #5 had been sleeping in the	free of	certificate of Insurance to HCRC in carson city. or 12-20-09 after the survey, the bed was removed near the	
	but currently the bed was empty. The screens were missing from the back of house. The glass in the door leading into living room was shattered and covered with Employee #2 indicated there were no screwhen she bought the house. The employer revealed if she opened the windows she we pull down the blinds. The employee indicator rock had been thrown at the door. The own was looking to replace the glass.	eens ee vould ated a	after the survey, the bed was removed sear the fireplace as complied. after the survey, the windows were always closed and there were mo scream. The glass door was already corrected as complied.	
iš došaiausia	Severity: 2 Scope: 3		monifor as complied The owner will check that everythe	เกร

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. 15 correct

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Bureau of Health Care Quality & Compliance

STATEMENT	OF DEFICIENCE	ES
	E CORRECTION	

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING_

3646 BILLMAN AVE

		LAS VEGAS, NV 89					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	FIX (EACH CORRECTIVE ACTION SHOULD BE				
Y 272	Continued From page 14	Y 272					
Y 272 SS=C	449.2175(3) Service of Food - Menus	Y 272					
	NAC 449.2175 3. Menus must be in writing, planned a wadvance, dated, posted and kept on file flays.		after the Survey renus were clarged and constell the administrator will mornifor for compliance				
	This Regulation is not met as evidenced Based on observation and interview, the failed to provide weekly menus. Findings include:		C'00 CT				
	A list of meat items was identified by nur and was posted on the bulletin board in the family room. There were no documented the weeks or completed menu items. Babeef was listed under number 19.	the facility d days of	menus are followed and complied as corrected for enclosed menu pehedules.				
	Resident #1 was admitted on 1/9/07. The resident revealed they had not had the national items documented on the menu list. The indicated the facility did not serve beef with the residents would be served a hambur in awhile.	neat e resident ery often.	after the survey, menus with the checked and implemented conrectly.				
	Employee #2 indicated the facility would what they wanted and did not follow the food. The employee indicated she was a specific menu was required for each mean substitutions were to be written on the management of the food was when she took ownership of the factoritinued to use the same list.	list of not aware neal and nenu. vas being	monifor for compliance. The owner will make sure That menus are followed correctly and will be implemented everyday.				
	Severity: 1 Scope: 3		This deficiency will not occur again.				
			occur agus				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau d	of Health Care Quali	ty & Compliance					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3105AGC			(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED 12/19/2008		
NAME OF P	ROVIDER OR SUPPLIER	***************************************	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		<u> </u>
	HOUSE		3646 BILL	MAN AVE AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Y 274	Continued From pa	nge 15		Y 274			
Y 274 SS=C	449.2175(5) Servic	e of Food - Substituti	ions	Y 274			
	be documented and at least 90 days aft	for an item on the med kept on file with the ser the substitution of e posted in a conspicervice of the meal.	menu for curs. A				
	Based on observat	not met as evidence ion and interview, the menu substitutions.					
	Findings include:				Alter the survey	n 12-20 c	. Gr
		ecue beef was listed dwich, can corn and I for lunch.		y274	menus were che and corrected as	anged	*
	what they wanted a food. The employed a specific menu wa	ated the facility would and did not follow the se indicated she was as required for each r to be written on the r	list of not aware neal and		after the survey, menus were che and corrected an partial for referen The administrator will monifor for comp	ree. Il lance.	

Severity: 1 Scope: 3

continued to use the same list.

Y 435 449.229(4) Fire Extinguisher; Inspection SS=F

NAC 449,229

4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by

The employee revealed the list of food was being used when she took ownership of the facility and

The owner will help to monitor and implement the correct menus on a daily basis.

This deficiency practice will not happen again

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE (CONSTRUCTION
A. BUILDING	
D MARKE	

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE

3646 BILLMAN AVE

BILLMAN HOUSE			LAS VEGAS, NV 89121				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	FULL =	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 435	Continued From page 16		Y 435				
	a person certified by the State Fire Mars conduct such inspections.	shall to					
	This Regulation is not met as evidenced Based on observation, the facility failed to 2 of 2 facility fire extinguishers were inspannually.	d by: to ensure pected	y 435	after the survey, fire expinguishers were clocked and dated or			
:	Findings include:			12-19-08.			
	During the survey, it was observed the 2 fire extinguisher was last inspected on 3			The administrator will monifor that fine offinguish must be inspected communally			
	Severity: 2 Scope: 3			must be inspected annually	, ·		
Y 444 SS=F	449.229(9) Smoke Detectors		Y 444	See enclosed fire dill be and make detectors test	*		
33-1	NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.			due monthly as complis	4.		
	This Regulation is not met as evidenced Based on interview and record review, the failed to ensure smoke detectors were to out of the past 12 months (January, Feb March, April, May, June, July, August, Santamber, October, Nevember, and De	he facility ested 12 oruary,	प्रक्पव	after the survey, on 12 - 20 - sproke detectors was checked and come & recorded.	clad		
	September, October, November and De of 2008).	scerniner		No odominatates will			
	Findings include:			monifor for compliance			
	There was no documented evidence the detectors were checked. Upon tour of the apply amply detectors visualized was	he facility,		The administrator will morifu for compliance. This deficiency will not occur again			
doficionala	the only smoke detector visualized was s are cited, an approved plan of correction must be		n 10 days -5	tor receipt of this statement of deficiencies			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. 6899

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Bureau of Health Care Quality & Compliance

STATEMENT	OF	DEFICIENCIES
AND PLAN OF	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

B. WING

12/19/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE

3646 BILLMAN AVE LAS VEGAS, NV 89121

BILLMAN HOUSE LAS V			VEGAS, NV 89121				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 444	Continued From page 17		Y 444				
	the caregiver's bedroom.						
	Employee #2 indicated she was not aware checking smoke detectors or having small detectors in the facility.		y444	Employee # r is very amare of checking smake defectors and must be			
	Severity: 2 Scope: 3			defection and must be			
Y 455 SS=D	449.231(2)(e) First Aid Kit - <u>CPR Mask</u>		Y 455	recorded menthly.			
33-0	NAC 449.231 2. A first-aid kit must be available at the The first-aid kit must include, without lin (e) A shield or mask to be used by a peris administering cardiopulmonary resus	nitation: erson who		The owner will make sure That the deficient practice will not occur again.			
	This Regulation is not met as evidence	ad by:					
	Based on interview and observation, the failed to ensure a shield or mask was a staff.	e facility					
	Findings include:						
	During examination of the first aid kit, it observed a mask or shield was missing kit.		y 455	After the survey, or 12-2. The first aid kit was corrected and completed by mask. The administrator will	9-84		
	Employee #2 indicated she was not su happened to the mask.	ire what		of mask. The administrator will			
	Severity: 2 Scope: 1			morifor for complance. The first aid kit will			
Y 528 SS=F	449.260(1)(c) Activities for Residents		Y 528	be available for use			
				anytime and evenything			
	NAC 449.260			will be completedand checked.	<u></u>		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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(X3) DATE SURVEY COMPLETED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	•	(X2) MULTIPLE CONSTRUCTION A. BUILDING
	NVS3105AGC		B. WING
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE			.MAN AVE AS, NV 8912	21				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Y 528	Continued From page 18		Y 528					
	The caregivers employed by a reside facility shall: (c) Plan recreational opportunities that to the interests and capacities of the resident.	are suited						
	This Regulation is not met as evidence Based on observation and interview, the failed to provide activites suited to the reinterests.	e facility						
	Findings include:			after survey, on 12-20-09,				
	Employee #2 indicated the residents did to do the activites listed on the activity so The employee revealed the residents do leave the facility.	schedule.	4528	after survey, on 12-20-09, The activity schedule ups will be corrected and will be smited to				
	Resident #1 was admitted on 1/9/07. Tresident indicated she liked to read and to go to the library. The resident reveal could leave the facility to do what she whad to pay for a taxi or take the bus. The resident indicated she would feel like it imposition to the owner to transport her library unless it was a planned activity.	would like led she vanted, but he was an		the istests and capacities of the				
	Resident #1 revealed the facility did not activity schedule posted in the facility.	t follow the		The administrator will monifor for compliance. Periodent # 1 can go to the				
	Resident #4 indicated she would like to music.	listen to		Reidert # 4 las a radro				
	During the survey, two residents walked the living room for a few minutes then we family room and sat on the couch. This noted to be exercise time.	vent to the		Resident # 4 las a radio Resident # 4 las a radio to listen to anytime. This deficiency will not occur again.				
	es are cited, an approved plan of correction must b			cherry cours 4 1 facturing ments				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA



Bureau of Health Care Quality & Compliance

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AND	PI AN	OF C	ORRE	CTION	

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

BILLMAN HOUSE

3646 BILLMAN AVE LAS VEGAS, NV 89121

BILLMAN HOUSE		AS VEGAS, NV 891	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 528	Continued From page 19 Severity: 2 Scope: 3	Y 528		
Y 773 SS=D	NAC 449.2726 1. A person who has diabetes must not be admitted to a residential facility or be permiremain as a resident of a residential facility unless: (a) The resident's glucose testing is perform by: (1) The resident himself, without assistator	itted to , med		
	This Regulation is not met as evidenced be Based on interview and record review, the failed to ensure blood glucose testing for 1 diabetic residents was performed by the rethemselves without assistance (Resident #Findings include:	facility of 1 esidents	Evaluate the residents criferia to make some that the incident will not beggeen again the survey, resident # 6 is no longer in the facility. This incident will not	
	Resident #6 was admitted on 10/27/03 and discharged on 11/7/08. Diagnoses include Alzheimer's Disease, Dementia, Diabetes, Diverticulitis, Congestive Heart Failure and Chronic Atrial Fibrillation.	ed 19773	resident # 6 is no longer in the facility.	very depth of the control of the con
	A record of capillary blood sugars was note the resident file. The results were docume twice a day.		This incident will not occur again.	
	Employee #2 revealed she would check th residents blood sugar twice a day. The reswas receiving Insulin twice a day.		The administrator will not morntor for compliance	ا
	Severity: 2 Scope: 1			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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PUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS NEVADA

APR 1) 2009

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS. NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG DEFICIENCY) Y 859 Y 859 Continued From page 20 Y 859 449.274(5) Periodic Physical examination of a Y 859 SS=F | resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. after the survey, lesidant 1, 2 +3 had their annual physician efam with their physician is no longer in the facility.

Pesilant # 1 has done or 1-21-09. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to obtain the results of an initial and/or annual physical examination for 4 of 6 residents (Resident #1, #2, #3 and #5). Findings include: Resident #1 was admitted on 1/9/07 with diagnoses including Hypertension and Hypothyroidism. The resident's record failed to provide documented evidence of the results of an

Resident #2 was admitted on 11/24/06 with diagnoses including Advanced Dementia, Hypertension, Cardiac Arrhythmia, Improved

physical examination for 2008.

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Anemia and Urinary Tract Infection. The initial physical exam was completed on 11/24/06. The resident's record failed to provide documented evidence of the results of an annual physical

initial physical examination for 2007 or an annual

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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an 2-18-09.

~ 2-10-09.

Resident # > was done

Bureau o	of Health Care Quali	ty & Compliance					
		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		NVS3105AGC		D. VIIIO_		12/1	9/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
BILLMAN	N HOUSE			MAN AVE AS, NV 8912	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
Y 859	diagnoses including	07 and 2008. dmitted on 2/1/08 wit		Y 859	after the survey, at 3 had her pho	resident Cysical	
	Vertebral Compres Hematoma and Me physical exam was resident's record fa	sion Fracture, Subdu echanical Fall. The ir completed on 12/4/0 ailed to provide docur sults of an annual phy	ıral nitial		If administrator The administrator monifor for couple Physical Exam will an mully for after the survey, resident # 5 is	mill ince. be done compliance	
	transferred on 1/15 Urinary Tract Infect Hypertension, Dep of Seizure Disorde Anxiety Disorder a Agoraphobia. The completed on 1/30 failed to provide do	dmitted on 2/1/07 and 5/08. Diagnoses inclution, Psychosis, Dem ression, Memory Los r, History of Gastroer and Panic Disorder with initial physical examulation of the resident's recumented evidence all physical examination.	nteritis, th was ecord of the	4858	Show incident in accin again. Well make son	ill met	
Y 870 SS=C		ope: 3 449.2742(1)(a)(1) Me	edication	Y 870	physical examination of the physical examination system been established.	r	
	provides assistance administration of new (a) Ensure that a period registered nurse we interest in the facility	physician, pharmacist tho does not have a f	or		been established.		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

appropriateness, at least once every 6 months the regimen of drugs taken by each resident of

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WNG NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG **DEFICIENCY**) Y 870 Y 870 Continued From page 22 the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 4 of 5 residents residing in the facility for longer than six months (Resident #1, #2, #5 and #6). Findings include: after the survey resident # 1, 2 was provided with medication profile review made by their Resident #1 was admitted to the facility on 1/9/07. There was no medication profile review in the record. Resident #2 was admitted to the facility on 11/24/06. There was no medication profile Ple administrator mill monifor every 6 months for compliance. Resident S + 6 is no review in the record. Resident #5 was admitted to the facility on 2/1/07

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

and transferred on 1/15/08. There was no

Resident #6 was admitted to the facility on 10/27/03 and discharged on 11/7/08. There was one documented medication profile review in the

medication profile review in the record.

record dated 5/6/08.

Y 876 449.2742(4) NRS 449.037

Severity: 1 Scope: 3

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Y 876

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longer in the facility.

This peactice will not occur again.

The owner will monitor too, for compliance.

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 876 Y 876 Continued From page 23 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449,037 are met. This Regulation is not met as evidenced by: NRS 449.037(6). The Board shall adopt separate regulations regarding the assistance which may be given pursuant to NRS 453.375 < NRS and 454,213 to an ultimate user of controlled substances or dangerous drugs by employees of residential facilities for groups. NRS 453.375 Authority to possess and administer controlled substances. A controlled substance may be possessed and administered by the following persons: 6. An ultimate user or any person whom the See enclosed documents as complied.

in 12-20-09 after the survey all residents were provided ultimate user designates pursuant to a written agreement. NRS 454.213 Authority to possess and administer dangerous drug. A drug or medicine referred to in NRS 454.181 to 454.371, inclusive, 4876 may be possessed and administered by: 10. An ultimate user or any person designated by the ultimate user pursuant to a written with an ultimate uses agreement. Based on record review, the facility failed to ensure an ultimate user agreement was signed The administrator mill for 6 of 6 residents (Resident #1, #2, #3, #4, #5 monifor for compliance this practice will be completed and #6). Findings include: and corrected. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM MLGM11

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

3646 BILLMAN AVE

		LAS VEGAS, NV 8			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	Continued From page 24 Resident #1 was admitted on 1/9/07. The resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Resident #2 was admitted on 11/24/06. resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Resident #3 was admitted on 2/1/08. The resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Resident #4 was admitted on 8/7/08. The resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Resident #5 was admitted on 2/1/07. The resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Resident #6 was admitted on 10/27/03. resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Resident #6 was admitted on 10/27/03. resident's file did not contain a signed user agreement that authorized the facilitation and insister medications to the resident. Employee #2 inidicated she was not awaresidents required a user agreement.	The Itimate lity to the It	b or 12-20-09, all residents were provided with ultimate user agreement signed by each are this deficiency will not occur again the owner will monifor for compliance. He administrates and aconer well assist		
Y 877 SS=F	Severity: 1 Scope: 3 449.2742(5) OTC medications & Dietai Supplements	y Y 877	yearly basis, that it will be implemented. Je enclosed documents as complied.		
	NAC 449.2742	a national vitable 40 day	as complied.		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

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BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA

SUPERAL OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA

PRINTED: 03/17/2009 FORM APPROVED

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 12/19/2008 NVS3105AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 877 Continued From page 25 Y 877 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medication and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. after the survey 1,600 the facility with obtain physician orders to administer for all residents.

The administrator will monitor for compliance. The owner will see to it This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to obtain physician orders to administer over-the-counter (OTC) medications for 3 of 6 residents (Resident #2, #3 and #6). Findings include: 1. Resident #2 was admitted on 11/24/06 with diagnoses including Advanced Dementia, Hypertension, Cardiac Arrhythmia, Improved Anemia and Urinary Tract Infection. The December 2008 medication administration that the deficiency will not record indicated the resident was receiving Calcium 500 +D three times a day, Aspirin 325 ocour again. milligrams (mg) once a day and One daily for Women one time a day. The medication administration records indicated the resident had received the medications for the past 6 months. There was no documented evidence of a physician order for the medications. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

Bureau of Health Care Quality & Compliance

MAY 0 7 2009

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If continuation sheet 26 of 49

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 12/19/2008 NVS3105AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 877 Y 877 Continued From page 26 Employee #2 reported the physician told her she did not need a prescription due to the medications could be purchased over the counter. Resident #3 was admitted on 2/1/08 with diagnoses including Osteoporosis, Hypothyroidism, Hypertension, Hyperlipidemia, Vertebral Compression Fracture, Subdural Hematoma and Mechanical Fall. The December 2008 medication administration on 12-20-09, the owner ask all physician for white a prescription on all over the counter drugs for all residents who needs it. 4877 record indicated the resident was receiving Centrum Silver at 8 AM. The medication administration records indicated the resident had received the medication for the past 6 months. There was no documented evidence of a physician order for the medications. Employee #2 reported the physician told her she did not need a prescription due to the medications could be purchased over the this practice will not counter. occur agein 3. Resident #5 was admitted on 2/1/07 and transferred on 1/15/08. Diagnoses included Urinary Tract Infection, Psychosis, Dementia, Hypertension, Depression, Memory Loss, History of Seizure Disorder, History of Gastroenteritis, Resident #5 is notengen Anxiety Disorder and Panic Disorder with Agoraphobia. in the facility.
This deficiency was corrected with not happen again The November 2007, December 2007 and January 2008 medication administration record indicated the resident was receiving a multivitamin once a day. There was no

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

documented evidence of a physician order for the

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medication.

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If continuation sheet 27 of 49



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Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** Y 877 Y 877 Continued From page 27 Resident #6 is not living in the facility.

this deficiency will not occur again. 4. Resident #6 was admitted on 10/27/03 and discharged on 11/7/08. Diagnoses included Alzheimer's Disease, Dementia, Diabetes, Diverticulitis, Congestive Heart Failure and Chronic Atrial Fibrillation. The November 2008 medication administration record indicated the resident was receiving Calcium 600 three times a day and a multivitamin once a day. There was no documented evidence of a physician order for the medications. Severity: 2 Scope: 3 Y 878 Y 878 449.2742(6)(a)(1) Medication / Change order SS=I NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review the facility failed to ensure the medication prescribed by a physician was administered as prescribed for 4 of 6 residents (Resident #1, #2, #3 and #5). Findings Include: for Complian If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 28 of 49

FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3646 BILLMAN AVE **BILLMAN HOUSE** LAS VEGAS, NV 89121 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ΙĎ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 878 Y 878 Continued From page 28 all medication will be checked and corrected in a daily basis for compliance. 1. Resident #1 was admitted on 1/9/07 with diagnoses including Hypertension and Hypothyroidism. On 9/24/08 the physician wrote a prescription for Levothyroxine 50 micrograms (mcg) to be given daily. The instructions on the prescription container (dated 2/1/08) indicated Levothyroxine 75 mcg to be given daily. after the surney, the charges and dosage of medications were corrected for all Resident #1 revealed she had been on Levothyroxine 75 mcg for a long time. Her physician assistant was no longer in town and she changed to a new physician. The physician had written several medication orders on the same prescription. One of the medications was not covered at the pharmacy used by the resident. The resident revealed the physician rewrote for the medications and changed the Levothyroxine to 75 mcg. The original prescriptions were never given to the pharmacy. monitor for compliance.

The owner will make sure

that the deficiency will

not occur again. There was no documented evidence of the new prescription change in the resident file. All the Medication Administration Records (MAR's) for Resident #1 indicate Levothyroxine .05 milligrams (mg) to be given daily. Employee #2 revealed the typist hired completed the monthly medication administration records and must not have changed the dosage. The employee also indicated the doctor kept changing the dose of the Levothyroxine.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

2. Resident #2 was admitted on 11/24/06 with diagnoses including Advanced Dementia, Hypertension, Cardiac Arrhythmia, Improved

Anemia and Urinary Tract Infection.

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Bureau of Health Care Quality & Compliance

STATEMENT	OF	DEF	CIEN	CIES
AND PLAN OF	F C	ORRE	CTIC	N

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
BUILDING	,

NVS3105AGC

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE		3646 BILL LAS VEGA	MAN AVE AS, NV 8912	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PRÉFIX TAG	Continued From page 29 On 10/18/08, Namenda 5 milligram give tablet daily was filled at the pharmacy. tablets were distributed. The day of sur were 3 tablets left in the container. Employee #2 revealed she put Novemb December pills in the October container Namenda. She indicated another pharm delivering the medication and it was not effective. When the employee was not pills were filled by the initial pharmacy, the employee then indicated the facility was pharmacy the employee stated was to compare the pharmacist at the pharmacy. The prindicated Namenda had not been refilled November. On 10/15/08, Digoxin 0.125 milligram grablet daily was filled at the pharmacy. The prindicated the facility was filled at the pharmacy. The prindicated Namenda had not been refilled November.	e one Thirty vey, there er and r of macy was cost fied the the susing the expensive. spoke with sharmacist d in ive one Ninety ation of the size of mployee ion	PREFIX TAG Y 878	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) after the survey all medications were corrected and checked for all residents. The administrator will make sure that all medications will be that all medications will be	COMPLETE
	remaining in the prescription bottle. The 67 tablets of a large yellow pill, 14 tables medium yellow pill and 63 tablets of a syellow pill. The October medication administration record indicated the Digital discontinued on 10/15/08. Employee #2 indicated the physician stop Digoxin due to the recall of the medical There was no documented evidence of physician order to stop Digoxin. The enrevealed she picked up the new prescription of 10/15/08 since it was alruent and the resident may need them in the	ets of a small exin was copped the cion. i a mployee iption refill eady filled		checked everyday. This deficiency will not occur again. Vell check all mediculions on a daily basis as compled.	1
	The employee was unable to explain w			the receipt of this statement of deficiencies	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 30 of 49

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FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WNG NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Y 878 Y 878 | Continued From page 30 were three different types of pills in the Digoxin container. On 12/19/08 at 8:50 AM, the surveyor spoke with the pharmacist at the pharmacy. The pharmacist identified 3 different manufacturers of Digoxin from the numbers on the tablets. The pharmacist indicated the Digoxin their pharmacy used was the medium yellow pill. On 12/23/08 at 12:45 PM, the surveyor spoke after the survey, 0,12-20.09 all medications were checked and corrected for all residents. with the pharmacist at the pharmacy where the medications were filled. The pharmacist revealed 4878 the Digoxin recall was in April 2008. On 7/14/08, Alprazolam 0.25 milligram give 1 tablet two times a day was filled at the pharmacy. Employee #2 was requested to count the medication remaining in the prescription bottle. There were 110 pills left in the container. Employee #2 indicated she dumped the new pills number for compliance the owner will checked into the older container. There was no medication log available to review to reveal when the medication was delivered to the facility. all medications un 3. Resident #3 was admitted on 2/1/08 with daily basis diagnoses including Osteoporosis, Hypothyroidism, Hypertension, Hyperlipidemia, This deficiency practice will not happen again Vertebral Compression Fracture, Subdural

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Hematoma and Mechanical Fall.

The prescription container dated 11/19/08 indicated L-Thyroxine 88 micrograms to be given daily. The June medication administration record

showed Levothyroxine was changed to 88 micrograms. There was no specific date noted on the medication administration record of the date the prescription was changed. There was no documented evidence in the resident file of a

If continuation sheet 31 of 49

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Bureau of Health Care Quality & Compliance

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AND	PLAN	OF C	ORREC	TION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	
B. WING	4044010000
	12/19/2008

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE			MAN AVE AS, NV 8912	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878		dication. for July, or and e 0.100 m 0.25 needed if through on was was ents ust have do the use the it. The other took her acility on realed the She was ription to ablet daily ets were count the n bottle.	Y 878		
	Employee #2 indicated she dumped the into the older container. There was no medication log available to review to re	veal when			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA

PRINTED: 03/17/2009 **FORM APPROVED** Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 878 Continued From page 32 Y 878 the medication was delivered to the facility. 4. Resident #5 was admitted on 2/1/07 and transferred on 1/15/08. Diagnoses included Urinary Tract Infection, Psychosis, Dementia, Hypertension, Depression, Memory Loss, History of Seizure Disorder, History of Gastroenteritis, Anxiety Disorder and Panic Disorder with Agoraphobia. Upon discharge from a local hospital on 5/16/07, the following medications were ordered

1. Alprazolam 0.5 milligrams two times a day for anxiety. Next dose due 5/16/07 at 9pm. 2. Lexapro 10 milligrams daily for depression.

Next dose due 5/17/07 at 8am. 3. Namenda HCL 5 milligrams two times a day

for dementia. Next dose due 5/16/07 at 9pm. 4. Levothroid 25 micrograms daily before meal

for hypothyroidism. Next dose due 5/17/07 at

5. Metoprolol 50 milligrams two times a day for hypertension. Next dose due 5/16/07 at 9pm.

6. Dilantin 200 milligrams two times a day. Next dose due 5/16/07 at 9pm.

7. Ambien 10 milligrams at bedtime if needed for insomnia.

The May 2007 and June 2007 medication administration record indicated the resident received Phenytoin Sodium (Dilantin) 100 milligrams at 8 am, 12 noon and 6pm, Levothyroxine 0.05 milligram at 8am, Metoprolol 25 milligram at 8am and 6 pm, Lisinopril 10 milligram at 8am and Warfarin Sodium 5 milligram at 6pm.

The July 2007 and August 2007 medication administration record indicated the resident

y 878

on 12-20-09, all medications were corrected and checked. The owner and the administrator will see to it that all medications were administered correctly. This deficiency with not occur again.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Health Care Quality & Compliance

STATEM	ENT OF	DEFICIENCIES	3
AND PLA	NOFC	ORRECTION	

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
BUILDING	
3. WING	12/19/2008

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

3646 BILLMAN AVE

			3646 BILLMAN AVE LAS VEGAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 878	received Zolidem 10 milligram 6 pm, Me 50 milligram at 8 am and 6 pm, Lexapro milligram at 8 am and Alprazolam .5 mil 6pm. There was no documented evided physician orders for the discontinuation Alprazolam, Namenda, Warfarin, Lisino Levothyroxine or Dilantin. The September 2007 medication administration indicated the resident received 2 milligram at 6 pm, Metoprolol 50 milligram and 6 pm and Alprazolam 0.5 milligram and 6 pm and Alprazolam 0.5 milligram. There was no documented evident physician order for the discontinuation of Lexapro. The October 2007 medication administration indicated the resident received Metopromilligrams at 8 am and 6 pm and Alprazolam. The November 2007, December 2007 January 2008 medication administration indicated the resident received Metopromilligrams at 8 am and 6 pm, multivitant am and Alprazolam 0.5 milligrams at 6 There was no documented evidence of physician order for the order of multivitation or descriptions.	o 10 Iligram at nce of of pril, iistration Colidem 10 am at 8 ram at 6 ce of a of orazolam der for the and n record olol 50 nin at 8 pm.	y 878	m 12-20-09 all hedications were corrected and checked properly the owner and adminis- thator will monitor for compliance this deficiency will not ocan again.		
Y 884 SS=D	Complaint #NV00017024 449.2742(8) Medication Administration		Y 884			
	NAC 449.2742 8. An employee of a residential facility	shall not				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
A. BUILDING	
B. WING	40440400

NVS3105AGC	

STREET ADDRESS, CITY, STATE, ZIP CODE

3646 BILLMAN AVE

			GAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 884	Continued From page 34 draw medication into a syringe or administer an injection unless authorized by law to do so.		Y 884			
	This Regulation is not met as evidenced Based on interview, the facility failed to e the employee would not draw medication syringe for 1 of 6 residents (Resident 6).	ensure n into a				
	Findings include: Resident #6 was admitted on 10/27/03 and discharged on 11/7/08. Diagnoses included Alzheimer 's Disease, Dementia, Diabeted Diverticulitis, Congestive Heart Failure and Chronic Atrial Fibrillation.	nd ded des, nd	y 884	resident #6 is no longer in the facility. this deficiency will not occur again. the administrator and		
	Novolin 70/30, 10 Units before breakfast Units before supper were ordered to be subcutaneously. Employee #2 revealed she would draw upper supper sup	and 5 given up the		occur again. the administrator and ill momitor		
	resident's insulin into the syringe to make the resident received the correct dose. I employee indicated the resident would the her own injection.	The		owner will momitor for compliance.		
Y 890 SS=C	Severity: 2 Scope: 1 449.2744(1)(a)(1) Medication / Receipt L	Log	Y 890			
	NAC 449.2744 1. The administrator of a residential facili provides assistance to residents in the administration of medication shall mainta (a) A log for each medication received by a specific an approved plan of correction must be	ain: by the				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA

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Bureau of Health Care Quality & Compliance

STATEMEN [®]	T OF	DEFICI	ENCIES
AND PLAN (OF CO	ORREC	TION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE C	ONSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

I DULMAN HOUSE			3646 BILLMAN AVE LAS VEGAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 890	Continued From page 35		Y 890			
	facility for use by a resident of the facility log must include: (1) The type and quantity of medicati received by the facility.					
Y 922 SS=B	This Regulation is not met as evidence Based on observation, interview and reveiew, the facility failed to maintain a M Receipt Log for 6 of 6 residents (Reside #3, #4, #5 and #6). Findings include: There was no documented evidence of medication receipt log kept in the facility resident's files. Employee #2 indicated no one told her needed to keep a medication log. Severity: 1 Scope: 3 449.2748(3)(a) Medication Labeling NAC 449.2748 3. Medication, including, without limitation over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the the resident for whom it is prescribed a name of the prescribing physician.	a y or the she on, any	y 890 Y 922	after the survey, the facility provided each secribents a medication secretary tog, and it will be rainfained in the residents file correctly. The administrator will mornifor for compliance. This deficiency will not occur again. See enclosed receipt logs for residents.		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 36 of 49

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	١
MAD LEVIA OL COMPECTION	L

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED

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STREET ADDRESS, CITY, STATE, ZIP CODE

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3646 BILLMAN AVE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PRÉFIX TAG Y 922	Continued From page 36 This Regulation is not met as evidence Based on interview and record review, tfailed to ensure medications were plaint for 2 of 4 residents who had medication facility (Resident #2 and #3). Findings include: Resident #2 was admitted on 11/24/06. of Aspirin, Calcium and One Daily for Were located in the resident's medication and were not labeled with the resident's the name of the prescribing physician. Resident #3 was admitted on 2/1/08. A Centrum Silver was located in the resident's medication basket was not labeled with resident's name or the name of the prescribing. Employee #2 revealed she was not away bottle needed to be labeled with the name resident and the physician. Severity: 1 Scope: 2	d by: the facility ly labeled is in the A bottle Vomen on basket is name or A bottle of lent's the scribing	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) after the survey, medication for assistent # x # # 3 mere falcled as complied the administrator will monifor for compliance this deficiency will not consider will be labeled correctly for now or when the pure that	COMPLETE
SS=F	NAC 449.2748 3. Medication, including, without limitati over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it i administered.			redications will be labeled correctly with residents name as complied.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 37 of 49

MAY 0 7 2009

PRINTED: 03/17/2009 **FORM APPROVED** Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WNG 12/19/2008 NVS3105AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Y 923 Y 923 Continued From page 37 after the survey of the facility will make sure that medications will be This Regulation is not met as evidenced by: Based on interview, the facility failed to keep medications belonging to 3 of 4 residents, who were receiving medications currently in the in their original confairer. facility, in their original container (Resident #1, #2 and #3). It was connected night away, often the survey. The administrator will Findings include: Employee #2 indicated revealed she would take medications out of the bubble packs and put into the plastic container. Severity: 2 Scope: 3 Complaint #NV00017024 Y 933 Y 933 449.2749(1)(d)(1) Resident File SS=C NAC 449,2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of his statement of deficiencies.

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that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical

information and any other information related to

(1) A description of any medical conditions

the resident, including without limitation: (d) A statement from the resident's physician concerning the mental and physical condition of

which require the performance of medical

the resident that includes:

services.

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Bureau of Health Care Quality & Compliance

STATE	MENT	OF	DEFIC	IENCIES
AND PI	ANO	FOC	PRRE (CTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	J
B. WING	

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

3848 BILLMAN AVE

BILLMAN HOUSE		16 BILLMAN AVE S VEGAS, NV 891	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 933	Continued From page 38	Y 933		
	This Regulation is not met as evidenced by: Based on interview and record review, the fa failed to ensure a physician statement was completed for 4 of 6 residents (Resident #1, #4 and #5).	acility		
	Findings include: Resident #1 was admitted on 1/9/07. There	was UG23	atten the survey the facility	4
	no documented evidence in the resident file completed physician statement.	of a 9733	provided a completed	
	Resident #3 was admitted on 2/1/08. There no documented evidence in the resident file completed physician statement.	was of a	after the survey of the facility provided a completed physician statement for resident 1, 3 + 4 in their files.	
	Resident #4 was admitted on 8/7/08. There no documented evidence in the resident file completed physician statement.		This deposit of again - see	
	Resident #5 was admitted on 2/1/07. There no documented evidence in the resident file completed physician statement.	ī	peribert #5 is no longer in the facility. The administrator will monitor for compliance.	
	Employee #2 indicated she was not aware a physician statement was required.		The administrator will monitor for compliance.	
	Severity: 1 Scope: 3		this deficiency will not occur again.	
Y 936 SS=F	449.2749(1)(e) Resident file	Y 936	occur again.	
	NAC 449.2749	.	1 / manuary / 1	}
	1. A separate file must be maintained for ea		all residents files	
	resident of a residential facility and retained		all residents files with confain physician statements as complied.	
	least 5 years after he permanently leaves the facility. The file must be kept locked in a pla		of the Total of the second	7
1.0.1	es are cited, an approved plan of correction must be retu		schenera an unplied	

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FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 12/19/2008 NV\$3105AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG DEFICIENCY**) Y 936 | Continued From page 39 Y 936 that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: the file was corrected and it will contain all records related to the NAC 441A.380 is hereby amended to read as follows: 441A.380 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing, residents without or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission this deficiency with not occur again.

The administrator and owner with monitor for to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing, or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; compliance. (3) Has blood in his sputum; (4) Has a fever assess residents carefully lefue admitting to the facility. which is not associated with a cold, flu, or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who

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has active tuberculosis.

(b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA



Bureau of Health Care Quality & Compliance

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WNG

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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3646 BILLMAN AVE

BILLMAN HOUSE LAS V		LAS VEGA	S, NV 8912	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 40		Y 936	18	
	person qualified to administer the test in facility or home when the patient is admit there is not a person qualified to administest in the facility or home when the person admitted, the staff of the facility or home ensure that the test is performed within after a qualified person arrives at the fachome or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the of a two-step Mantoux tuberculin skin tet the 12 months preceding admission, ensure the person has a second two-step Mantous tuberculin skin test or other single-step tuberculosis screening test. After a person had an initial tuberculosis screening test facility or home shall ensure that the person a single tuberculosis screening test annothereafter, unless the medical director of designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of test documents that determination. The risk exposure and corresponding frequency examination must be determined by folk guidelines as adopted by reference in person with a documented history of positive tuberculosis screening test is exposure tuberculosis screening test is exposure that the person is evaluated annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines described in paragraph (a) or subsection 2, the person may be admitted that a person has had a cough for more weeks and that he has one or more of the symptoms described in paragraph (a) or subsection 2, the person may be admitted facility or home if the staff keeps the person exposure cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an approved plan of correction must be are cited, an a	itted. If ster the son is shall 24 hours cility or sfirst step st within sure that oux on has t, the rson has ually r his sting and of of owing the aragraph of a xempt est or home d at least from the stan 3 he other fed to the rson in		all residents will have their TB fest done every year. The administrator and the administrator and the owner will see to that that this deficiency will not occur again. all staff will do the same every year, about TB testing. Bee enclosed documents as amphied for all ter receipt of this statement of deficiencies.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. RECEIVED 11 of 49

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BUREAU OF LICENSURE AND CERTIFICATION
LAS YEGAS, NEVADA

Bureau of Health Care Quality & Compliance

STATEMENT OF D	EFICIENCIES
AND PLAN OF COR	RRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE C	CONSTRUCTION
A. BUILDING	
B. WNG	

(X3) DATE SURVEY COMPLETED

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STREET ADDRESS, CITY, STATE, ZIP CODE

			MAN AVE AS, NV 8912	21	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	respiratory isolation in accordance with guidelines of the Centers for Disease C. Prevention as adopted by reference in p. (h) of subsection 1 of NAC 441A.200 ur health care provider determines whether person has active tuberculosis. If the stable to keep the person in respiratory is the staff shall not admit the person until care provider determines that the person to have active tuberculosis. 5. If a test or evaluation indicates that a has suspected or active tuberculosis, the facility or home shall not admit the person to refer the facility or home, or, if he has already admitted, shall not allow the person to refer the facility or home, unless the facility of keeps the person in respiratory isolation person must be kept in respiratory isolation to longer infectious. A health care proving the person has active tuberculosis or ce although the person has active tuberculosis or ce although the person has active tuberculosis or ce although the person with active tuberculosis and the person with active tuberculosis. The summary that the person is treated for the in accordance with the recommendation centers for Disease Control and Prevention as adopted by reference in (g) of subsection 1 of NAC 441A.200.	ontrol and paragraph atil a set the aff is not colation, a health on does person to be been emain in the ation until a set person rtifies that, closis, he is ider shall exculosis is poider has enegative ted on that active ome shall edisease as of the antion for ent for, a uidelines paragraph	Y 936	Sel enclosed TB fest for all residents as complied.	
If deficiencie	7. The staff of the facility or home shall are cited, an approved plan of correction must be		hin 10 days aff	er receipt of this statement of deficiencies	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA

APR 1 1 2009

FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WNG NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Y 936 Continued From page 42 Y 936 that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person's medical record. Based on record review, the facility failed to ensure 6 of 6 residents complied with NAC 441A.380 regarding tuberculosis (Resident #1, #2, #3, #4, #5 and #6). y936 Resident # 1 took her TB test on 3-13-09. Findings include: Resident #1 was admitted on 1/9/07. The file contained documentation the resident completed the required two-step TB skin testing on 2/23/07. The file did not contain proof the resident received an annual one-step TB skin test for 2008. Resident # 2 fook her TB fest on 2-27-09. Resident #2 was admitted on 11/24/06. The file contained documentation the resident completed the first step of the required two-step TB skin testing on 11/25/06 with no results documented. The second step was given on 11/29/06 with no documentation of results. Another TB skin test was given on 12/5/06 and read as negative. The

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

file did not contain proof the resident received an

report dated 1/22/08. The resident's file did not contain documentation the resident completed

annual one-step TB skin test for 2008.

the required two-step TB skin testing.

Resident #3 was admitted on 2/1/08. The resident's file contained a negative chest x-ray

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TB fest on 2-11-09.

Resident # 3 fook her

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Bureau o	f Health Care Quali	ty & Compliance				FORM A	APPROVED	
STATEMENT	TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING B. WING			G	(X3) DATE SURVEY COMPLETED	
		NVS3105AGC	STREET AD	DESS CITY	STATE, ZIP CODE	12/18	9/2008	
NAME OF PI	ROVIDER OR SUPPLIER			MAN AVE	SIAIE, ZIF CODE			
BILLMAN	HOUSE	•		AS, NV 891:	21			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
Y 936	resident's file contaresident completed two-step TB skin to contain evidence the second step. Resident #5 was astransferred on 1/15 contained document the first step of the on 1/19/07. The file resident completed not contain proof the one-step TB skin to Resident #6 was a resident's file contaresident completed 8/8/04. The file cocompleted a two-sident the file did not correceived an annual 2005, 2006 and 2005.	dmitted on 8/7/08. Tained documentation the first step of the rest on 7/27/08. The fire resident complete dmitted on 2/1/07 and 1/08. The resident of the resident of the second step. The did not contain evident for 2008. In the second step. The resident received est for 2008. In the second step. The resident of the second step. The resident received est for 2008. In the second step. The resident on 10/27/03. Sained documentation at two-step TB skin test on 10 train proof the resident of 10 train proof the 10 train proof train proof the 10 train proof tr	the required ile did not did the did not did the did not diffile completed a skin test dence the he file did an annual did the test on a resident 0/13/07. Intest for did not		after the survey rest fook her TB fest on Posiblest # 5 is no in the facility. Pesident # 6 is longer in the for momitor we shall for this deficiency in the owner will about deficiency.	lorger no cility.		
Y 938 SS=A	8 449.2749(1)(g)(1) Resident file		Y 938	about deficiency	fon			

1. A separate file must be maintained for each

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM MLGM11

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Bureau of Health Care Quality & Compliance

STATEMENT	OF DEFICIENCIES
AND PLAN OF	F CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION					
A. BUILDING	. =				
B. WING					

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

BILLMAN HOUSE		3646 BILLMAN AVE LAS VEGAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 938	resident of a residential facility and retailleast 5 years after he permanently leave facility. The file must be kept locked in a that is resistant to fire and is protected a unauthorized use. The file must contain records, letters, assessments, medical information and any other information rethe resident, including without limitation: (g) An evaluation of the resident's ability perform the activities of daily living and description of any assistance he needs perform those activities. The facility sha such an evaluation: (1) Upon the admission of the residents	ned for at es the a place against a all elated to a brief to all prepare	Y 938		
	This Regulation is not met as evidence Based on record review, the facility fails perform an initial assessment for 2 of 6 for their abilities to perform the activities living (ADL) (Resident #2 and #5). Findings include: Resident #2 was admitted on 11/24/06. assessment was completed on 3/7/07. was no other ADL assessment in the record Resident #5 was admitted on 2/1/07 and transferred on 1/15/08. There was no documented evidence of a completed A assessment on admission. Severity: 1 Scope: 1	The ADL. There esident file.	y938	check all ADL every 51x months for comphance on 12-20-09 after the survey the facility made a complete ADL for residents#2. Resident 5 is no longer in the facility. The administrator will Tromfor for comphance again	

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PRINTED: 03/17/2009 **FORM APPROVED**

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3646 BILLMAN AVE **BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 940 Continued From page 45 Y 940 Y 940 Y 940 449.2749(1)(g)(3) Resident file SS=C NAC 449 2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all m 12-20-09, a 4940 records, letters, assessments, medical information and any other information related to separate file was rainfaired and corrected the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief for each resident. In annual enaluation will description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (3) In any event, not less than once each year. be performed. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to perform an annual evaluation of a for compliance resident's ability to perform the activities of daily living (ADL) for 4 of 4 residents residing in the facility longer than a year (Resident #1, #2, #5, #6). Findings include: Resident #1 was admitted 1/9/07. The resident's 4940 file did not contain an annual evaluation of the resident's ability to perform the activities of daily

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NO			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS3105AGC		B. WING _	· · · · · · · · · · · · · · · · · · ·	12/19	/2008
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
BILLMAN	HOUSE			.MAN AVE AS, NV 891:	21		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
Y 940	Resident #2 was ac resident's file did no of the resident's ab daily living for 2008	dmitted 11/24/06. The contain an annual illity to perform the add.	evaluation ctivities of	Y 940			
	transferred on 1/15 contain an annual of	dmitted on 2/1/07 and i/08. The resident's to evaluation of the resine activities of daily line activities of daily line	ile did not dent's	y940	Resident # 5 is in the facility.	vo longer	
	discharged on 11/7 contain an annual dability to perform the 2008. Employee #2 indicates a second contains an annual dable and annual dable annual dable and annual dable and annual dable and annual dable annu	dmitted on 10/27/03 7/08. The resident's evaluation of the resine activities of daily limited she thought the	file did not dent's ving for residents		Reachest # 6 is longer in the face this kind of definitely as The administration of	no- ility.	
	admission.	DL assessment comp	Dieted on		This kind of defin will met happen as	jain.	
Y 960 SS=D	NAC 449.2754 1. A residential factorize for residents a related dementian its license authorize	imer's endorsement ility which offers or p with Alzheimer's dise nust obtain an endors ing it to operate as a which provides care t	ase or sement on	Y 960	The administrator a complete mon comphence. See enclosed for residents complete as comphed.	nd For for the CEIVED	
	Based on record re provide a license v	not met as evidence eview, the facility faile vith an endorsement th dementia (Reside	ed to to provide		SUREAU OF LICE	R I O 2009 Ensure and certifica Evegas, heyada	TION

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STAT	TEMEN	NT OF	DEFIC	IENCIES
AND	PLAN	OF C	ORREC	CTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED

NVS3105AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

		3646 BILLMAN AVE LAS VEGAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE	
Y 960	Continued From page 47	Y 96)		
	Resident #2 was admitted on 11/24/06 widiagnoses including Advanced Dementia Hypertension, Cardiac Arrhythmia, Improvemental and Urinary Tract Infection. Resident #6 was admitted on 10/27/03 addischarged on 11/7/08. Diagnoses inclus Alzheimer 's Disease, Dementia, Diabet Diverticulitis, Congestive Heart Failure at Chronic Atrial Fibrillation. The facility license did not have an Alzheinendorsement. The three employees of the did not have any training in relation to Aldisease in 2008. Employee #2 indicated the physician and	vith a, byed and ded tes, and eimer's the facility zheimer's	2 d	After the survey, Resident # has no dimentia. Resident # 6 is no longer in the facility. We facility will make sure not to take alsteiners client, anymore: the administrator will monitor for compliance.	
	requested Resident #2 remain in the factor her sister also lived in the facility. The expending indicated she would notify the family of inappropriate placement in the facility. Employee #2 indicated Resident #6 had	mployee		The owner will be very careful in Jaking chiento. This deficiency will not lappe, or occur again.	
[-	Severity: 2 Scope: 1			lappe, or occur)	
	Complaint #NV00017024			Enaluate He residents interia, before admiting the resident.	
YA566 SS=D	449.267(2)(a-c) Money & Property of Re	esidents YA5		, and the second	
If deficiencie	NAC 449.267 2. An accurate record must be kept of all deposited with the facility for use by the including withdrawals. The record must (a) A separate accounting of the money the facility on behalf of the resident; see cited, an approved plan of correction must be	resident, include: held by	- 1	Inclosed are the Physicians assessment for each of the receipt of this statement of deficiencies.	

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LAS YEGAS NEVADA

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3105AGC 12/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3646 BILLMAN AVE BILLMAN HOUSE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) YA566 Continued From page 48 **YA566** (b) Receipts for expenditures made by the facility on behalf of the resident; and (c) A written acknowledgement by the resident for each withdrawal of his money. 04/2-20-09 after the survey the facility will make sure that receipts and with acknowledgeout will be provided to residents about money matters. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 residents signed a written statement allowing the facility to handle their money (#5). Findings include: Resident #5 was admitted on 2/1/07 and transferred on 1/15/08. The resident's record did not contain a signed statement allowing the The administrator will facility to handle her money. monifor for complaine. This deficiency will not occur again. Employee #2 confirmed the written statement was not in the record. The employee indicated the resident would just sign over her social security check. The employee revealed she would spend any left over money on the resident. Scope: 2 Severity: 1 all deficiencies made Complaint #NV00017024 in 2008 will not occur again. We learn from one mistakes. This year will better, as complied

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